Question	Response
-If we are billing Time Based (seeing the patient for 55 mins), does the chart need to be completed on the SAME DAY or could be completed with a week?	Charting time that takes place the next day or after will not count for overall time. That being said, no you do not have to complete the documentation the same day if billing based on time. Just remember that time cannot count.
If appointment is coded by time spent, does note have to be completed by 24 hours-?	Charting time that takes place the next day or after will not count for overall time. That being said, no you do not have to complete the documentation the same day if billing based on time. Just remember that time cannot count.
-Would it be helpful from a documentation/support standpoint when finding an undiagnosed new problem of uncertain prognosis, to include a differential diagnosis in the note? -	Yes it certainly would help to support a higher level E/M code when the final diagnosis may not support without more context.
-The US National Center for Health Statistics describes a chronic illness as anything lasting greater than 3 months. That is how our practice is defining chronic conditions from a MDM standpoint. -	There is a lot of discrepancy, but the CDC does state a chronic conditon needs to last a year. Chronic diseases are defined broadly as conditions that last 1 year or more. The condition you are classifying as "chronic" should be understood to last for a year for most people.
-Does the time taken to chart (say an extensive history) count towards time - to code for time for level of service?	Yes so long as it happens on the date of the face to face encounter.
-If a chart is being reviewed to determine level of E&M supported, in order to give credit as a stable "chronic" condition or "chronic" illness with exacerbation...does the provider have to document that the condition is expected to last at least a year or can they document the word "chronic" or an onset date of at least a year in the past to satisfy? Or are there certain conditions expected to be "chronic" and by addressing that condition, "chronic" is supported?-	Some conditions are understood to be chronic and there is no need to state that. However, most chronic conditions are addressed differently than acute problems in that care plans are established or goals to ensure that the patient has limited exacerbations and disruptions to quality of life. To support stable versus unstable having that documented is important. However, for conditions that are typically acute in nature but can turn chronic, it is important to document that because in many instances that impacts the ICD-10-CM code selection.
-If an in house COVID test is ordered and is negative, but based on symptoms, the provider orders a test to be sent out to the lab, does that count as one unique test or two?-	While some may consider this a separate test, it is unclear how auditors will view this especially if it is general practice, rather than a true cognitive process for the physician to do a send out.
Would doing a COVID test be consider “low” or “minimal” risk for morbidity-	Nasal swabs would qualify for low morbidity.

Would more than one historian (like two different parents) give two points in this category (for data)	No, a historian counts only for 1 point it is not cumulative. It states "historian(s)" so even more than one will not change points given.
-Can we include time spent on day after encounter when we call parents back with COVID test results? If not, how do we account for this time?-	This is post-service time and is not counted under "time." If this leads to another treatment route or a change in the MDM for the patient and the bill was not submitted yet, then you can add to the MDM and code based on the new information. Note that if you spent more than 30 mins on the calendar date, it is possible to instead report non-direct prolonged care (99358).
-I understand that in the vingette of waiting for the throat culture, you can still code Level 4 for Risk as the possibility of antibiotics was discussed even if not prescribed at the time.-	That depends, not everyone will discuss treatment options on the day of the encounter. The example was when treatment was not discussed. But remember if you do that, the documentation must support the discussion around treatment and why you did not give that treatment.
-How do we hold onto documentation and billing for days while awaiting test results to support higher MDM (level of coding) when we have to complete charting by midnight of the patient's date of service?-	You can complete the documentation but it does not have to be billed out. Discuss further with your EMR and billing office. If new information comes in that you were waiting on (X-rays, lab tests) and you add to the notes in an attestation, you can possibly count towards a higher level .
-If we are doing an infusion and we are spending say 60 minutes observing different patients all in the same room, do we code 992x5 for EACH patient? Each patient is given the infusion, one after the other but are all observed.-	No, time in an E/M service is ONLY counted once per patient per physician and would not be appropraite in this situation - it would be fraud to say you spent 60 mins total with a patient when you are also caring for other patients at the same time. If you want to discuss this further please send a message to https://form.jotform.com/Subspecialty/aapcodinghotline
-how should we document that there was an independent historian used?	There should be a place in the EMR and if not, in the notes to say "mom provided the history" or "dad provided additional details regarding the patient's illness. Something similar so that an auditor can clearly pick that out.
-For Data: LIke for a level 4 visit, when 3 things are needed from category 1, would more than one historian (like two different parents) give two points in this category, especially if they have different information? -	No, a historian counts only for 1 point it is not cumulative. It states "historian(s)" so even more than one will not change points given.
-When perfomring a Well Child does the Well Child DX need to be addressed?-	Please send your question in as I was unclear https://form.jotform.com/Subspecialty/aapcodinghotline
-Do you consider quarantine requirement as determinate of health-	No, this is not part of social determinants of health.

-schedule a fu visit as telemed-	Please send your question in as I was unclear https://form.jotform.com/Subspecialty/aapcodinghotline
-When billing time based do you need to report Time started and time stop?-	That was not the intent of CPT. Total time should be enough documentation.
-Example: if you are testing someone for COVID and they just have an exposure and you discuss possibiities, and you spent 10 min to dx a 99212?	If documented time is 10 mins then yes this is a 99212. As long as the provider is a physician or advanced practitioner (eg, NP, PA)
-Can you comment on how gastroenteritis fits as a systemic illness but otitis does not?-¬Just to clarify the above, I mean otitis with fever as the only "systemic" symptom¬	*CPT*® defines an *illness with systemic symptoms* as one with a **high risk of morbidity without treatment.** If the situation is such that the fever in and of itself creates a high risk of morbidity, such as a very high fever with risk for dehydration, then make that clear in your documentation. Likewise, a mild case of gastroenteritis does not constitute "high risk of morbidity." Use your judgement about severity in each situation and DOCUMENT to justify that a higher level MDM was indicated.
-for a child with respiratory symptoms, but no fever, for whom we are testing for COVID, would that be considered an "undiagnosed problem with an uncertain prognosis"? Rationale being that, if it turns out to be COVID, that the prognosis is by definition uncertain, especially if they have high risk other conditions? -	Each situation is different; use your documentation to justify your code selection. For example, one child with only respiratory symptoms might have a PMH of mild intermittent asthma and currently has a mild-to-moderate cough without wheezing or increased work of breathing; I would consider that child to have 1 acute, uncomplicated illness. Another child with only respiratory symptoms might have a PMH of immunodeficiency disorder with cough and increased work of breathing; I would consider that child to have 1 undiagnosed new problem with uncertain prognosis. If the work of breathing is severe (such that hospitalization is considered), then I would consider the situation 1 acute illness that poses a threat to life/bodily function. A diagnosis of Covid-19 is not necessarily an uncertain prognosis. We now know that in MOST children, it is mild illness. However, it could be "an uncertain prognosis" in certain cases, especially in a patient with other risk factors such as obesity, chronic lung disease, kidney disease, diabetes, sickle cell disease, and others. Make sure to document your thought process to justify the MDM involved.

-We are doing virtual visits in instances when our patients need a COVID test because of post-exposure clearance. The children do not have symptoms. We have had some providers code this a 99213, some a 99212. It depends on how to interpret the "risk" of the test". We presume it is a self limited minor problem to have asymptomatic testing. If that same patient has a diagnosis of asthma or diabetes, and it is discussed that a positive result may lead to further intervention would it increase level of care?	If the patient only needs a Covid-19 test to return to school/sports/etc, but they have no symptoms, then I would advise this does not necessitate an physician or QHP-provided E/M service. They only need a lab service. In this situation, the patient could be sent to a drive through testing center or tested in the office using 99211. A patient with Covid-19 positive test, but no symptoms, may require guidance in isolation protocols, supportive care if symptoms begin, and when it is appropriate to go to the emergency room. Perhaps in that situation, the MDM would be number/complexity = 1 self-limited problem (as no symptoms); data = either minimal or possibly low if independent historian (depending on age of the patient and other factors); risk = minimal risk from additional testing/treatment as you are doing no additional testing/treatment. If you are spending a lot of time with the patient, then document time and submit the service based on time.